ICD-9-CM Committee Discusses Code Proposals for 2004: Approved Changes Would be Effective October 1, 2003

by Sue Prophet-Bowman, RHIA, CCS

The ICD-9-CM Coordination and Maintenance Committee, cosponsored by the National Center for Health Statistics (NCHS) and the Centers for Medicare & Medicaid Services (CMS), met in December 2002, in Baltimore, MD. Donna Pickett, RHIA, from NCHS, and Patricia Brooks, RHIA, from CMS, cochaired the meeting.

Proposed modifications to ICD-9-CM were presented and are summarized below. This summary of the Coordination and Maintenance Committee meeting is provided for information purposes only. The comment period for the proposed revisions has expired.

Diagnoses

Minutes from the diagnosis portion of the Coordination and Maintenance Committee meeting, as well as complete details of the code proposals, can be found on the NCHS Web site at www.cdc.gov/nchs/ icd9.htm.

Septic Shock and Sepsis

The terms septic shock, severe sepsis, sepsis, and septicemia are often used interchangeably by clinicians, but they are clinically distinct conditions that have very different clinical pictures and outcomes. Septic shock is a unique form of shock resulting from combined decreased systemic vascular resistance and the presence of myocardial performance. The clinical picture of severe sepsis, systemic inflammatory response syndrome (SIRS) with organ dysfunction, must be present for a patient to advance to septic shock. Patients with septic shock represent a subset of those with severe sepsis. Septic shock is the end point of the continuum from sepsis to severe sepsis to septic shock.

New codes for SIRS and severe sepsis became effective October 1, 2002. Another new code for septic shock (to be created in subcategory 785.5, Shock without mention of trauma) is being proposed for implementation on October 1, 2003. It is also being proposed that the term "sepsis" be added as an inclusion term under code 995.91, Systemic inflammatory response syndrome due to infectious process without organ dysfunction, and that the term "sepsis" be indexed to code 995.91.

A note would appear under the new code for septic shock instructing coders that code 995.92, SIRS due to infectious process with organ dysfunction, must also be assigned. A note would be added under category 038, Septicemia, to instruct coders to assign an additional code for the corresponding SIRS. Both the proposed instructional notes include a statement indicating that sequencing is discretionary. This created concern among meeting participants because it is unclear who has this discretion and under what circumstances the sequencing is discretionary. It was suggested that a note be added under code 995.92 instructing coders to also assign the new code for septic shock (to correspond to the note under the proposed new code).

Dementia

Dementia with Lewy bodies is a dementia with Parkinsonian motor features. Unexplained falls are a predominant early feature. Pathologically, it differs from Parkinson's disease in that the Lewy body intracellular inclusions are also found frontally, not just within the basal ganglia. This cerebral degeneration is also manifested by greater neuropsychiatric features than Alzheimer's disease, with more prominent hallucinations. Patients with this form of dementia may worsen with phenothiazine-like medications, which are commonly used for psychoses.

Frontotemporal dementia differs from Alzheimer's disease by its frontal lobe personality changes such as impulsivity, disinhibition, loss of social awareness, and lack of attention to personal hygiene. Language may also be affected. Other

cognitive functions may not be as impaired as in Alzheimer's disease. Age at onset of frontotemporal dementia is often in the 50s.

New codes for dementia with Lewy bodies and frontotemporal dementia have been proposed in subcategory 331.8, Other cerebral degenerations. Because a subset of frontotemporal dementia is Pick's disease, which already has its own code, this condition would be excluded from the new code.

It was suggested that because the coding conventions for Pick's disease and Alzheimer's disease all require an additional code to identify dementia (294.10 or 294.11, Dementia in conditions classified elsewhere, without or with behavioral disturbance), perhaps the use of the proposed new code for frontotemporal dementia should be structured the same way.

Scrotal Transposition

Scrotal transposition is a congenital anomaly whereby the scrotum is transposed above the penis. It looks like the penis and scrotum are reversed. The testes are also involved. It is treated surgically. An expansion of code 752.8, Other specified anomalies of genital organs, has been proposed in order to create a new code for scrotal transposition. Other concomitant anomalies should be coded separately.

A meeting participant suggested that consideration be given to creating a unique code for penile scrotal webbing in addition to a code for scrotal transposition.

Peyronie's Disease

Peyronie's disease is fibrosis of the cavernous sheaths leading to contracture of the fascia of the corpora resulting in a deviated and painful erection. The cause is unknown. Resolution may occur spontaneously over many months. Minor disease that does not cause sexual dysfunction does not warrant treatment. Treatment may consist of vitamin E, steroid injections, radiation, antihistamines, or surgical repair. Treatment results are unpredictable. A new code for Peyronie's disease has been proposed in subcategory 607.8, Other specified disorders of penis.

Penile Injury

Severe injuries to the penis are most commonly caused by crushing blows and avulsion of the skin and genitalia. Avulsion injuries among factory and farm workers can happen when clothing is caught in machinery. Avulsion of the penis may also occur due to various devices (such as penile rings or vacuum cleaner attachments) or excessive trauma during sex.

It has been proposed that specific codes for injuries to external genital organs be created instead of continuing to classify them to code 959.1, Injury, other and unspecified, trunk. The new codes would uniquely identify injuries of the breast, vulva, penis, scrotum, testes, and buttocks. Specific injuries classified elsewhere, such as open wounds, would not be assigned one of the new codes.

Urgency of Urination

Urinary urgency is an intense need to urinate. A new code has been proposed in subcategory 788.6, Other abnormality of urination.

Nonvisible Ureter

A urologist may be called in to insert ureteral stents preoperatively to assist the primary surgeon in visualizing the ureters prior to open abdominal exploration or hysterectomy. A new code for nonvisible ureter has been proposed in subcategory 593.8, Other specified disorders of kidney and ureter. If the reason for the nonvisualization of the ureter is hydronephrosis, the new code would not be assigned. Instead, hydronephrosis would be coded.

Some participants raised objections to this proposal, because the new code would imply that there is an abnormality or disease of the ureter when, in fact, nothing is wrong with it. However, many participants agreed that it is important to provide a code

for this situation, because there is no other code that would explain why ureteral stents were inserted. It was suggested that a code in category 793, Nonspecific abnormal findings on radiological and other examination of body structure, or a V code be created instead of a code in category 593.

Impaired Fasting Glucose

Impaired fasting glucose has been defined as > 110 mg/dl but < 126 mg/dl. This is distinct from an abnormal glucose tolerance, which is defined as a glucose obtained during an oral glucose tolerance test of Ž 140 mg/dl but < 200 mg/dl.

These metabolic stages are different from normal glucose homeostasis and diabetes. Although there are usually no clinical signs or symptoms related to impaired fasting glucose, the clinical implications of early identification of patients at risk for diabetes and its associated cardiovascular disease are important. The first and second phase of insulin release are impaired in these patients, indicating beta cell dysfunction. Cardiovascular risk factors are significantly raised in all types of non-diabetic hyperglycemia. The greatest effect on mediating cardiovascular complications will occur in patients identified at the earliest stages of impaired glucose homeostasis.

It has been proposed that the description of code 790.2 be changed to “abnormal glucose test” and that this code be expanded to create two new codes for impaired fasting glucose and abnormal glucose tolerance test. A meeting participant suggested changing the word “impaired” to “elevated,” as a low fasting glucose could also be considered “impaired.” An additional suggestion was made to add a third code for “other abnormal glucose test” to be able to code an abnormal non-fasting glucose.

Carnitine Deficiency

Carnitine is an essential metabolic intermediary that is a critical factor for mitochondrial energy production and essential for normal biochemical function. Carnitine deficiency occurs with certain genetic abnormalities, certain medical conditions, and from treatments for diseases. Patients with carnitine deficiency may develop cardiomyopathy, Reye-like encephalopathy, hypoketotic hypoglycemia, hypotonia, muscle weakness, and certain dialysis-related problems such as intra-dialytic hypotension and erythropoietin-resistant anemia, plus failure to thrive.

There are two forms of carnitine deficiency, primary and secondary. Primary carnitine deficiency is caused by a defect in the transporter responsible for the carnitine uptake from plasma to the tissues. Primary carnitine deficiency is a permanent condition that currently requires chronic therapy with L-carnitine. Secondary carnitine deficiency may be divided further into that which is due to genetic defects and that which is due to iatrogenic factors. Secondary carnitine deficiency is more common than the primary type and is mainly due to inborn errors of metabolism. It may also result from medical conditions such as cirrhosis, Fanconi syndrome, and HIV, or from treatments for diseases such as hemodialysis and valproic acid therapy.

An expansion of code 277.8, Other specified disorders of metabolism, has been proposed to create several new codes for carnitine deficiency. These proposed new codes include primary carnitine deficiency, carnitine deficiency due to inborn errors of metabolism, iatrogenic carnitine deficiency, and other secondary carnitine deficiency. Because carnitine deficiency due to hemodialysis may be accompanied by hypotension, a new code for hypotension of hemodialysis has also been requested.

Meeting participants generally felt that fewer codes describing carnitine deficiency should be created in order to allow for future expansion in subcategory 277.8 for other conditions. It was suggested that only codes for primary, secondary, and unspecified carnitine deficiency be created.

Rhabdomyolysis

Rhabdomyolysis is an acute, sometimes fatal, disease marked by destruction of skeletal muscle. It may occur occasionally following strenuous exercise and in association with drugs that cause coma such as alcohol, heroin, or cocaine. Rhabdomyolysis is sometimes the reason cardiac enzymes are elevated when a myocardial infarction has been ruled out. When associated with crush syndrome, whereby muscle tissue disintegrates due to prolonged, continuous pressure, it is referred to as traumatic rhabdomyolysis.

A new code for rhabdomyolysis has been proposed in subcategory 728.8, Other disorders of muscle, ligament, and fascia. Both traumatic and non-traumatic rhabdomyolysis would be classified to this code.

Hypercoagulable States

The hypercoagulable states are a group of inherited and acquired disorders, which cause an increased risk of thrombosis. Theprimary hypercoagulable states are generally inherited abnormalities of specific proteins, particularly the anticoagulant factors that normally break down blood clots. Examples of primary hypercoagulable states include antithrombin III deficiency, protein C deficiency, protein S deficiency, activated protein C resistance (Factor V Leiden mutation), and prothrombin gene mutation.

The secondary hypercoagulable states are a diverse group of mostly acquired disorders, which predispose to thrombosis through complex and other multifactorial mechanisms. These mechanisms may involve abnormalities of blood flow, blood composition, and vessel walls. Some disorders that can cause a secondary hypercoagulable state include malignancy, myeloproliferative disorders, antiphospholipid antibody syndrome, pregnancy, and trauma. Prognosis and treatment of a hypercoagulable state depends on the specific disorder involved. Anticoagulation therapy may be indicated short term, or in some cases, for a lifetime.

An expansion of code 289.8, Other specified diseases of blood and blood-forming organs, has been proposed to allow creation of two new codes for primary and secondary hypercoagulable states.

Hyperaldosteronism

ICD-9-CM code 255.1, Hyperaldosteronism, includes several different states of aldosterone excess for which the diagnostic workup and treatment are different. It is also now known that the primary form of aldosteronism is responsible for the hypertension seen in 5 to 10 percent of patients with hypertension. It has been requested that code 255.1 be expanded to identify the different types of hyperaldosteronism. Distinct codes would be created for primary aldosteronism, secondary aldosteronism, Bartter's syndrome, glucocorticoid-remediable aldosteronism, and Conn's syndrome.

Barrett's Esophagus

Barrett's esophagus is a metaplastic disorder in which specialized columnar epithelium replaces healthy squamous epithelium. It is an acquired condition, secondary to chronic gastroesophageal reflux damage to the esophageal mucosa. Currently, Barrett's esophagus is indexed to code 530.2, Ulcer of esophagus. This code does not appropriately capture the inherent physiologic changes to the structure of the mucosal lining of the esophagus and lower esophageal junction. A unique code has been proposed in subcategory 530.8, Other specified disorders of esophagus.

Early Satiety

Early satiety occurs when someone is hungry and eats, but feels full quickly. This symptom is common in many conditions, including brain tumors or hormonal problems. A new code for early satiety has been proposed in subcategory 780.9, Other general symptoms.

Encounter for Emergency Contraception

Codes exist for encounters for prescriptions for oral contraceptives and other forms of birth control, but no code exists for an encounter for emergency contraception. A new code has been proposed in subcategory V25.0, Encounter for contraceptive management, General counseling and advice.

Thoracoscopic Procedure Converted to Open Procedure

A code exists for laparoscopic procedure converted to open procedure (V64.4). A similar code for thoracoscopic procedure converted to open procedure has been requested. Meeting participants suggested that consideration be given to simply expanding the description of code V64.4 to include thoracoscopic procedures.

Subaponeurotic Hemorrhage (Subgaleal Hemorrhage)

Caput succedaneum, cephalhematoma, chignon, and subaponeurotic hemorrhage (subgaleal hemorrhage) are currently all classified to code 767.1, Injuries to scalp. The first three of these conditions are common events after normal spontaneous vaginal delivery or uncomplicated forceps or vacuum extraction deliveries, and they have no significant associated morbidity or mortality.

Subgaleal hemorrhage (SGH) is a relatively rare occurrence, but it is associated with high rates of morbidity and mortality (3 to 23 percent). The frequency of this injury in this country has increased as the percentage of vacuum extraction deliveries has increased. It has been proposed that code 767.1 be expanded to create a unique code for SGH.

Postpartum Cardiomyopathy

Cardiomyopathy may occur in the postpartum period in women without pre-existing heart disease. It tends to affect multiparas women over age 30, those carrying multiple fetuses, and those whose pregnancies are complicated by pre-eclampsia. It has a mortality rate of 50 percent within five years and a high probability of recurrence in subsequent pregnancies, which are therefore contraindicated.

Postpartum cardiomyopathy is currently an inclusion term under subcategory 674.8, Other and unspecified complications of the puerperium, not elsewhere classified. Creation of a new code for postpartum cardiomyopathy in category 674, Other and unspecified complications of the puerperium, has been proposed.

Late Infant

When code 645, Late pregnancy, was expanded to create codes for post-term pregnancy and prolonged pregnancy, a similar modification was not made to the corresponding newborn code, 766.2, Post-term infant, not “heavy for dates.” Therefore, code 766.2 does not correspond to either of the codes or definitions in category 645. An expansion of code 766.2 has been proposed, to be consistent with the maternal codes.

Loss of Consciousness in Mild Traumatic Brain Injury

In recent decades, public health officials have become increasingly aware that the consequences of mild traumatic brain injury may not be all that mild. Clinical research has shown that these injuries can cause serious, lasting problems. Responding to a mandate from Congress, the National Center for Injury Prevention and Control and a group of experts have recommended methods to assess the incidence of prevalence of mild traumatic brain injury in the United States. For this purpose, a surveillance definition of mild traumatic brain injury was established.

One of the criteria for this definition is either observed or reported loss of consciousness lasting 30 minutes or less. Mild traumatic brain injuries are classified to the codes for concussion, which indicate the length of loss of consciousness. Currently, the shortest time frame identified in the existing codes is less than one hour. Because this time frame does not conform to the surveillance definition established for mild traumatic brain injury, it has been proposed that code 850.1, Concussion with brief loss of consciousness, be expanded to create two new codes to distinguish concussion with loss of consciousness for 30 minutes or less and that between 31 to 59 minutes.

Cerebral Infarct of Unknown Vessel

Often a patient with confirmed occlusion of his or her precerebral and cerebral arteries may have signs and symptoms of a cerebral infarction, but it is not possible to determine the vessel responsible for the infarction. This situation results in difficulty correctly applying the fifth digits for categories 433, Occlusion and stenosis of precerebral arteries, and 434, Occlusion of cerebral arteries.

The fifth digits modify the codes to which they are assigned. If it cannot be determined that the site of an occlusion is also the site of the infarct, then it is incorrect to use a fifth digit of “1” (with cerebral infarction). In this case, use of the digit “0” (without mention of cerebral infarction) is also a problem because the patient clearly has a documented infarct. The use of code 436, Acute, but ill-defined, cerebrovascular disease, is illogical with a code that has a fifth digit stating the patient has an infarct.

In an attempt to solve this dilemma, a new fifth digit, "with cerebral infarction of other or unspecified vessel" has been proposed for use with categories 433 and 434. The existing fifth digit of "1" would be retitled to state "with cerebral infarction of this vessel." The meeting participants agreed that a solution is needed to resolve the problems surrounding the use of the cerebral infarction codes, but they felt that the proposed solution is not the answer and could result in more confusion. Some of the codes in category 433 and all of the codes in category 434 do not specify a vessel, so the phrase "this vessel" in the proposed new fifth digit is confusing. It was suggested that in addition to resolving the problems with use of the fifth digits in categories 433 and 434, it would be helpful if a code were created for "stroke, not specified as a hemorrhage or infarction." Unspecified strokes are currently classified to code 436, which is considered extremely nonspecific.

Hair Tourniquet Syndrome

Hair tourniquet syndrome, also referred to as hair strangulation, is the external constriction of a finger, toe, or the external genitalia, by hair. The external constriction may also be due to thread, a ring, a rubber band, or any other object that can go around a body part. It is a relatively common finding in infants. It may be an emergency situation if the object is not removed, as an infection or amputation could result. Hair is most commonly associated with toes and external genitalia, while thread is more often found around fingers.

External constriction is classified as a superficial injury. There is no external cause code to specify the object causing the constriction. Two new E codes for external constriction caused by hair and caused by other object have been proposed in category E928, Other and unspecified environmental and accidental causes.

Addenda

Proposed October 2003 addenda changes were reviewed. Highlights of the proposed revisions include:

- deletion of inclusion term under code 491.21, Obstructive chronic bronchitis, with acute exacerbation, for "acute bronchitis with chronic obstructive pulmonary disease"
- addition of Excludes note under code 614.6, Pelvic peritoneal adhesions, female (postoperative) (postinfection) for "pelvic peritoneal adhesions complicating pregnancy or labor (648.9)"
- addition of Excludes note under code 965.1, Poisoning by analgesics, antipyretics, and antirheumatics, Salicylates, for "salicylates used for (as): antiplatelet (964.8) or antithrombotic (964.8)"
- addition of Index entry for accelerated angina (411.1)
- addition of "poorly controlled" as a non-essential modifier for the Index entries for diabetes
- addition of Index entry for severe obesity (278.01)
- addition of Index entry for vasculopathy, cardiac allograft (996.83)

Procedures

Minutes from the procedural portion of the Coordination and Maintenance Committee meeting, as well as complete details of the code proposals, can be found on the CMS Web site at www.cms.gov/paymentsystems/icd9.

Total Replacement Heart System

A patient that is a candidate for a replacement heart is either in class IV heart failure (New York Heart Association Functional Classification) or has an acutely failing heart that is not treatable by other medical means. Class IV patients are unable to carry on any physical activity without symptoms. Symptoms are present even at rest, and, if any physical activity is undertaken, they increase. Terminal acute heart failure patients do not recover due to irreversible heart muscle damage. Symptoms of heart failure include shortness of breath, easy fatigability, edema, orthopnea, paroxysmal nocturnal dyspnea, jugular venous distention, or rales.

There is currently an artificial replacement heart system in clinical trials. Implantation of this system involves a number of steps. Pockets for the implanted transcutaneous energy transfer coil, the implanted battery, and the implanted controller are created. The ventricles are resected and the aorta and pulmonary artery are transected just distal to their respective valves. To assess the lengths for the outflow grafts, a plastic mold of the thoracic unit is placed in the chest. After determining the

appropriate length for the pulmonary arterial graft, this graft is cut and the thoracic model is removed. The pulmonary arterial graft is anastomosed to the pulmonary artery and the aortal graft is similarly anastomosed to the ascending aorta. The replacement heart thoracic unit is attached in sequence to the left atrium, pulmonary artery, aorta, and right atrium connectors.

The thoracic unit of the replacement heart system can be replaced or repaired. This process involves sternotomy and cardiopulmonary bypass just like for the initial implantation of the system. Replacement or repair of the implantable components, other than the thoracic unit, does not require a sternotomy or cardiopulmonary bypass. It does, however, require general anesthesia. The pocket containing the component requiring replacement or repair is bluntly dissected and the tunnel cables are accessed.

The implantable replacement component is bypassed in the system, and the function is temporarily taken over by an external controller. The component being replaced is removed. The replacement component is implanted and the corresponding cables are tunneled and connected to the replacement heart cable system, replacing the external controller temporarily used during the procedure.

New codes have been proposed for implantation of total replacement heart system, replacement or repair of thoracic unit of total replacement heart system, and replacement or repair of implantable component or components of total replacement heart system. The existing code for heart transplantation, code 37.5, would be retitled “Heart replacement procedures” and would be expanded to accommodate the new codes. The code for heart transplantation would also be located in this subcategory.

Until new codes become effective, implantation of total replacement heart system should continue to be assigned code 37.62, Implant of other heart assist system, and replacement or repair of total replacement heart system should be assigned code 37.63, Replacement and repair of heart assist system.

Multi-level Spinal Fusion

Current ICD-9-CM codes for spinal fusion and refusion do not capture the number of discs fused. A variety of proposals for code revisions to capture this information were discussed at the April 2002 Coordination and Maintenance Committee meeting. The previous proposals were complicated and had significant potential for causing confusion. A simpler, straightforward approach was presented at the December 2002 meeting and received general support from meeting participants.

Three new codes have been proposed in subcategory 81.6 that would capture the number of vertebrae fused or refused (two to three, four to eight, or nine or more). One of these codes would be assigned in addition to the appropriate code from subcategory 81.0, Spinal fusion, or 81.3, Refusion of spine, for the level and approach of the fusion or refusion. If a 360-degree spinal fusion is performed through a single incision, one of the new codes would be assigned in addition to code 81.61 to identify the number of vertebrae fused. A number of Index entries would be added to facilitate proper coding of spinal fusions and refusions.

High-dose Interleukin-2 (IL-2) Therapy

This topic was previously discussed at the November 2001 Coordination and Maintenance Committee meeting. There is no specific ICD-9-CM code for high-dose Interleukin-2 (IL-2) therapy. This therapy is currently coded with code 99.28, Injection or infusion of biological response modifier (BRM) as anti-neoplastic agent. This code also includes therapy using low-dose IL-2, anti-neoplastic immunotherapy, and tumor vaccine. Usage and provision of these products can be very dissimilar, and the use of a single code to describe them does not allow for the differentiation the varied courses of treatment require.

High-dose IL-2 therapy is a hospital inpatient-based regimen for treatment of patients with advanced renal cell cancer and advanced melanoma. Currently, this treatment modality is the only approved therapy in both stage IV metastatic renal cell carcinoma and stage IV metastatic melanoma. Unlike traditional cytotoxic chemotherapies that attack cancer cells themselves, high-dose IL-2 therapy enhances the body’s defenses by mimicking the way natural IL-2 activates the immune system and stimulates the growth and activity of cancer-killing cells.

High-dose IL-2 therapy has been shown to evoke an immune response in a subset of patients that completely eradicates the tumor, and the patient’s response is long lasting (more than 10 years for some patients). High-dose IL-2 therapy is performed only in very specialized treatment settings such as an intensive care unit or a bone marrow transplant unit. This therapy is

associated with predictable toxicities that require extensive monitoring. Typically, the institutions that provide high-dose IL-2 therapy have standing orders specifically for administration of this therapy.

A unique code for high-dose IL-2 therapy has been proposed in subcategory 00.1, Pharmaceuticals. Concerns that had been raised when this proposal was initially presented at the November 2001 Coordination and Maintenance Committee meeting related to whether the medical record documentation would clearly indicate whether the patient was receiving high-dose IL-2 therapy, as opposed to low-dose IL-2. However, it appears that the indications and treatment settings for the two types of IL-2 therapy are distinct enough that this should not be a significant issue. Low-dose IL-2 therapy is typically administered in the outpatient setting and for different indications. It was recommended that low-dose IL-2 therapy be specifically excluded from the new code.

Injection or Infusion of Therapeutic Radioimmunoconjugates (Radioimmunotherapy)

The use of monoclonal antibodies has recently been added to the treatment options available to patients with non-Hodgkin's lymphoma. Non-Hodgkin's lymphoma is the fifth most common type of cancer in the United States, and its prevalence is increasing at a rate approaching 4 percent per year. Conventional treatment depends on the stage of the disease, the type of cells involved (whether they are indolent or aggressive), and the age and general health of the patient. Non-Hodgkin's lymphoma can be treated with chemotherapy, radiation therapy, or a combination of the two treatments. In some cases, bone marrow transplantation, biological therapies, or surgery may be treatment options.

Monoclonal antibodies are used to destroy some types of cancer cells while causing little harm to normal cells. They are designed to recognize certain proteins that are found on the surface of some cancer cells. The monoclonal antibody recognizes the protein and attaches to it. This triggers the body's immune system to attack the cancer cells and can cause the cells to destroy themselves.

Throughout the past decade, further research has been conducted on the use of monoclonal antibodies to carry radioactive isotopes to tumor sites for the purpose of selective radiation of the tumor with relative sparing of normal tissues. These trials have involved patients with lymphoma and cancers of the breast, ovary, prostate, colon, and lung. The conjugation of monoclonal antibodies to radioactive isotopes creates products known as radioimmunoconjugates. The treatment of cancer patients with these products is commonly referred to as radioimmunotherapy.

A unique code for injection or infusion of radioimmunoconjugates was proposed in subcategory 92.2, Therapeutic radiology and nuclear medicine. However, due to limited space in the procedure section of ICD-9-CM and the fact that it is anticipated most of this type of therapy will be provided in an outpatient setting, it was recommended that a new code not be created at this time. Code 92.28, Injection or instillation of radioisotopes, should be assigned for this type of therapy.

Laparoscopic Supracervical Hysterectomy

The laparoscopic supracervical hysterectomy procedure spares the cervix and maintains the integrity of the pelvic floor, which helps to maintain internal pelvic support and causes no trauma to the vagina. Preservation of the cervix may result in fewer long-term problems with pelvic relaxation and urinary symptoms. Some disadvantages of traditional total abdominal hysterectomy include increased operative and postoperative complications, vaginal shortening, vault prolapse, abnormal cuff granulations, and oviductal prolapse, all of which are eliminated with a laparoscopic supracervical hysterectomy.

A laparoscopic supracervical hysterectomy is also known as classic infrafascial SEMM hysterectomy and laparoscopically assisted supracervical hysterectomy.

An expansion of code 68.3, Subtotal abdominal hysterectomy, has been proposed to create a unique code for laparoscopic supracervical hysterectomy. A code for "other subtotal abdominal hysterectomy" would also be created in this subcategory.

ICD-9-CM is not up to date with regard to describing procedures performed laparoscopically or thoracoscopically. It is anticipated that additional proposals for new codes will be discussed at future Coordination and Maintenance Committee meetings.

Addenda

Proposed October 2003 addenda changes were reviewed. Proposed revisions include:

- addition of an inclusion term for "re-programming of ventriculoperitoneal shunt" under code 02.41, Irrigation and exploration of ventricular shunt
- addition of an inclusion term for "electrophysiolic studies (EPS)" under code 37.94, Implantation or replacement of automatic cardioverter/defibrillator, total system (AICD), in order to clarify that EPS studies are included in this code and should not be coded separately
- addition of an inclusion term for "vertebroplasty" under subcategory 78.4, Other repair or plastic operations on bone
- addition of Index entries for biliopancreatic diversion (43.7[45.51][45.91]) and biliopancreatic diversion with duodenal switch (43.89[45.51][45.91]). Note that three procedure codes are necessary to describe both these procedures.
- addition of entry to indicate that no code should be assigned for a bedside evaluation or testing of an implantable automatic cardioverter/defibrillator
- addition of Index entries for Roux-en-Y gastroenterostomy and gastrojejunostomy (both procedures are assigned code 44.39)

The deadline for submitting agenda items for this meeting has expired. If approved, the changes would become effective on October 1, 2003. The next meeting of the ICD-9-CM Coordination and Maintenance Committee is scheduled for April 3-4, 2003.1,2

Notes

1. Diagnosis code proposals for future Coordination and Maintenance Committee meetings may be e-mailed to Donna Pickett at dfp4@cdc.gov or mailed to National Center for Health Statistics, ICD-9-CM Coordination and Maintenance Committee, 6525 Belcrest Road, Room 1100, Hyattsville, MD 20782.

2. Procedure code proposals for future Coordination and Maintenance Committee meetings may be e-mailed to Pat Brooks at PBrooks@cms.hhs.gov or mailed to Centers for Medicare & Medicaid Services, CMM, HAPG, Division of Acute Care, Mail Stop C4-08-06, 7500 Security Boulevard, Baltimore, MD 21244-1850.

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